State of Tennessee
Definition of Developmental Delay

The term “infant and toddlers with disabilities” means a child, from birth through age two, who is eligible for early intervention services because he or she:

Part A:

Is experiencing developmental delays, as measured and verified by appropriate diagnostic instruments, administered by qualified examiners, indicating that the child is functioning at least 25% below his or her chronological age in two or more of the following development areas:

- Cognitive development;
- Physical development, including fine motor, gross motor and sensory development, (vision and hearing);
- Communication development;
- Social/emotional development;
- Adaptive development

OR

Is functioning at least 40% below his or her chronological age in one of the areas listed above;

OR

Part B:

Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, i.e., known, obvious, or diagnosable conditions such as sensory losses and severe physical impairments. Examples include, but are not limited to:

- Hearing loss which can be verified or estimated to be significant as indicated through an audiological evaluation;
- Visual loss, which can be verified or estimated to be significant, for example: cataracts, glaucoma, strabismus, albinism, myopia, retinopathy of prematurity, or dysfunction of the visual cortex;
- Neurological, muscular or orthopedic impairment which prevents the development of other skills; for example, congenital dislocation of the hip, spina bifida, cerebral palsy, rheumatoid arthritis, autism, epilepsy;
- Organic conditions or syndromes which have known significant consequences; for example, tuberous sclerosis, hydrocephalus, muscular dystrophy, fetal alcohol syndrome;
- Chromosomal, metabolic, or endocrine abnormalities; for example, Down Syndrome, Klinefelter Syndrome, Turner Syndrome, hypothyroidism.

Eligibility for services shall be determined by a multidisciplinary team, based on a review of the results of an appropriate evaluation as described in Part A of this definition or the verification of a diagnosed condition as described in Part B of this definition.

ERIC Clearinghouse on Disabilities and Gifted Education
1110 North Glebe Road, Arlington, Virginia 22201-5704
1-800-328-0272 ericec@cec.sped.org http://ericec.org

The Implications of Culture on Developmental Delay

The ERIC Clearinghouse on Disabilities and Gifted Education (ERIC EC)
The Council for Exceptional Children
1110 N. Glebe Rd.
Arlington, VA 22201-5704
Toll Free: 1.800.328.0272
E-mail: ericec@cec.sped.org
Internet: http://ericec.org

ERIC EC Digest #E589
Author: Rebeca Valdivia
December 1999

Developmental delay refers to a lag in development rather than to a specific condition causing that lag. It represents a slower rate of development, in which a child exhibits a functional level below the norm for his or her age. A child may have an across-the-board developmental delay or a delay in specific areas.

When a child's development appears to lag, many service providers prefer to apply the less specific term "developmental delay," rather than a more specific disability diagnosis, since symptoms of specific disabilities may be unclear in young children. It is possible that a child with a developmental delay who receives services will not develop a disability; whereas if the same child did not receive services, the delay would become a disability. Because it is based on a comparison of the child's functional level with that of other children of the same age, "developmental delay" can be seen as a statistically defined, socially mediated construct that depends on cultural expectations and the definition of what constitutes a delay.

Developmental Delay under the Law

Prior to 1997, IDEA defined infants and toddlers with disabilities as individuals from birth through age two, inclusive, who need early intervention services because they

- Are experiencing developmental delay as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills
- Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

The 1997 reauthorization of IDEA added that "for children 3 through 9, the state and local education agency (LEA) may define 'child with disability' as a child who is experiencing developmental delays and needs special education and related services." Thus, these children do not have to be labeled with a specific category to receive special education services.

Developmental delay is often interpreted as the precursor to the label 'disabled' for children from birth to nine years old. For children of diverse cultural and linguistic backgrounds, professionals must be careful to avoid errors in diagnosis that stem from differences among various cultures and professionals about what constitutes a disability or delay.

Assessment/Diagnosis

When determining whether a child has a developmental delay, the law requires use of appropriate diagnostic instruments and procedures. Professionals working with young children have long accepted the shortcomings of standardized tools, since young children with or without delays are in a process of constant growth and change, which makes it difficult to capture the child's development accurately at any one 'measurement' or observation. In addition, young children seldom 'cooperate' according to the expectations of the developers of the assessment tools, thus contributing to a possible misdiagnosis.

Many professionals have chosen to use instruments and procedures referenced to local norms in order to obtain a more reflective picture of the child's development (i.e., they develop a tool that reflects the norms of their community rather than national norms). In determining the appropriateness of norm-referenced instruments for children from diverse backgrounds, it is essential to examine the populations on which the norms were based. The following questions apply:

- Were the norms inclusive of the diversity of families found in the communities across the United States with which the tool will be applied?
- Did these 'diverse' children also represent variations that typify the communities in which the tool will be applied? For example, children within a group may vary in socioeconomic status, languages spoken, immigration status, and diversification within a more global category (e.g., Hispanic [Spanish-, Cuban, Puerto Rican-, Peruvian-, Salvadoran-or Mexican-American]).

In addition, professionals involved in this step of the child's developmental evaluation should ask themselves the following:

- Does the tool or process include provisions to conduct the assessment in the child's dominant language(s)?
- Will specially trained personnel familiar with the family's culture, practices, and beliefs conduct the assessment?

If even one of the answers to any of the four questions was "no," then either the instrument or the process may be inappropriate for use with culturally and linguistically diverse families. Furthermore, the domains of development (e.g., cognitive, self-help, etc.) and the items subsumed in each area are predominantly reflective of a Western approach to the discussion and examination of early childhood development (Srinivasan & Karlan, 1997; Hehir & Latus, 1992). Although early childhood professionals may recognize the totality of the child, they may still feel comfortable separating aspects of the child's development into these component parts. Not only that, specialists (e.g., speech therapists) may address each component (e.g., speech and language) separately from the other components (e.g., gross motor). This may be in direct contradiction with monitoring the child's development from a more holistic, functional, situational approach common in other cultural groups (Kagitcibasi, 1996).

The age norms assigned to these various developmental domains are also quite arbitrary; they are primarily reflective of white, middle-class child rearing norms (e.g., Lynch & Hanson, 1992; Mangione, 1995). For instance, the entire self-help paradigm is indicative of the value of 'early independence' in these skills promoted by families in this group. Many families feel just as comfortable encouraging their child to independently spoon-feed shortly before the child attends public school at 5 or 6 years of age instead of at 18 months as expected in many developmental checklists. Many families also see no purpose in having their child drink from a cup before 3, 4, or 5 years of age. When there are other family members around to help the child dress, there is no pressure to encourage independent dressing early in the preschool years. These are a few

examples of different attainment of developmental milestones influenced directly by different child-rearing values and practices.

Professionals must determine if they are truly measuring all the skills that this child has learned or if they are only measuring those skills they value based on their upbringing and professional training. For example, Garcia Coll (1990) examined developmental skills such as tactile stimulation, verbal interaction, nonverbal interaction, and feeding routines. These skills were studied in multicultural families, including African-American, Chinese-American, Hopi, Mexican-American, and Navajo families. The study found that "minority infants are not only exposed to different patterns of affective and social interactions, but that their learning experiences might result in the acquisition of different modes of communication from those characterizing Anglo infants, different means of exploration of their environment, and the development of alternative cognitive skills." (p.274). Therefore, teachers and other service providers must distinguish between a developmental or maturational lag and behaviors that can be brought about by learning. For example, if a child is unable to spoon-feed, is it because she lacks the needed musculature and fine motor skill? Is it because she is neurologically unable to perform the complex movement? Or is it simply because she has not learned that skill and will easily learn it given the opportunity?

Disability or Delay within a Cultural Perspective

The discussion has thus led us to accept that disability is a socially and culturally situated construct (Danesco, 1997; Harry, 1992; McDermott & Varenne, 1996). Therefore, families of children of diverse cultures (and languages) may not identify a certain series of behaviors or symptoms as being descriptive of a 'delay' or 'disability'. For instance, in her review of the literature, Danesco (1997) found that many culturally diverse parents explained their child's condition as a combination of biomedical and sociocultural or folk beliefs. Families often saw their child's condition as temporary or something that could be remedied. Therefore, it is not uncommon to see families following a combination of 'professional/medical' prescriptions along with home remedies, folk or alternative practices in order to help their child. It should be noted that families varied in how much weight they ascribed to professional, educational, or medical interventions as compared to alternative interventions. Because families had different interpretations of what constituted a delay or disability, even having their child labeled led to misunderstandings and mistrust between them and the professionals who were attempting to be helpful. For example, if everybody else in the family had followed similar developmental patterns, what would the label 'developmentally delayed' given to the youngest child say about the rest of the family? If the child functioned well in the life of the home and community and the concern only existed in the clinic, school, or agency, was the child truly delayed?

Implications for Practice

The cultural implications of the developmental delay category underscore the importance of having a broad array of tools for assessment and instruction as well as a good understanding of the child's culture. Responsive, family-centered programs and professionals have taken many steps to ensure effective communication between them and the children they serve. These have included making interpreters available, making printed as well as audio/audio-visual materials available in the families' dominant language, and connecting parents to a network of other parents with similar issues.

Instruction for children with developmental delay should reflect the goals identified and mutually agreed upon by the interventionist, educators, specialists, and, of course, the family. The learning objectives should include the child's strengths as the foundation. They should be aimed at bridging the gap between what the child is currently able to do in his or her environment and what he or she needs to learn to do in order to be optimally successful in the current or upcoming environments. For instructional strategies and materials, professionals and families are

encouraged to implement multicultural practices which honor and respect every child's culture and language.

References

Danesco, E. R. (1997). Parental beliefs on childhood disability: Insights on culture, child development, and intervention. International Journal of Disability, Development, and Education, 44(1), 41-52.

Garcia Coll, C.T. (1990). Developmental outcome of minority infants: A process-oriented look into our beginnings. Child Development, 61(2) 270-289.

Harry, B. (1992). An ethnographic study of cross-cultural communication with Puerto Rican-American families in the special education system. American Educational Research Journal, 29 (3) 471-494.

Hehir, T. & Latus, T. (Eds.) (1992). Special education at the century's end. Cambrige, MA: Harvard Educational Review.

Kagitcibasi, C. (1996). Family and development across cultures: A view from the other side. Mahwah, NJ: Lawrence Erlbaum Associates.

Lynch, E.W. & Hanson, M.J. (1992). Developing cross-cultural competence.Baltimore, MD: Paul H. Brookes.

Mangione, P.L. (Ed.)(1995). A guide to culturally sensitive care. Sacramento, CA: California Department of Education.

McDermott, R. P. & Varenne, H. (1996). Culture, development, disability. In R. Jessor, A. Colby & R. A. Shweder (Eds.) Ethnography and human development. Chicago: The University of Chicago Press.

Srinivasan, B. & Karlan, G.R. (1997). Culturally responsive early intervention programs: Issues in India. International Journal of Disability, Development, and Education, 44(4), 367-385.

Top of Page Back to ERIC Menu Back to CEC Home Page

The Implications of Culture on Developmental Delay Worksheet

Read 7.1b – *The Implications of Culture on Developmental Delay* and complete this worksheet. Upon completion, return worksheet to the trainer/supervisor, and place in portfolio upon approval.

1. **Briefly describe two shortcomings of standardized tools that may contribute to a possible misdiagnosis when assessing young children.**

_____
_____
_____
_____

2. **Give an example from your own experience (or from the article) where child rearing values and practices influenced the attainment of developmental milestones in conflict with standardized age norms.**

_____
_____
_____
_____
_____
_____
_____

3. **List three things programs can do during assessment for developmental delay in order to ensure practices that honor and respect every child's culture and language.**

_____
_____
_____
_____
_____
_____

The Implications of Culture on Developmental Delay
Trainer's Key

Note to trainer/supervisor: Answers other than the ones listed below may also be correct. Use your own judgment in this regard.

Read 7.1b – *The Implications of Culture on Developmental Delay* and complete this worksheet. Upon completion, return worksheet to the trainer/supervisor, and place in portfolio upon approval.

1. **Briefly describe two shortcomings of standardized tools that may contribute to a possible misdiagnosis when assessing young children.**

Young children are in a process of constant growth and change, making it difficult to accurately capture the child's development at any one time, and young children seldom cooperate according to the expectations of assessment tools.

2. **Give an example from your own experience (or from the article) where child rearing values and practices influenced the attainment of developmental milestones in conflict with standardized age norms.**

Accept reasonable examples, such as:
When there are family members around to assist with dressing or feeding, the child may have no need or opportunity to practice these skills.

3. **List three things programs can do during assessment for developmental delay in order to ensure practices that honor and respect every child's culture and language.**

Have available a broad range of assessment tools
Develop a good understanding of the child's culture
Make interpreters/translators available as needed
Connect parents to a network of other parents with similar issues

Explanation of Evaluation/Assessment Procedures

In order to conduct an evaluation/assessment of a child, a variety of evaluation and assessment procedures will be used in order to gather relevant functional and developmental information. No single procedure or test will be used in determining a child's eligibility for early intervention services or in planning an early intervention program. CFR 303.323 Test and evaluation materials used to assess a child have been selected so as not to be discriminatory and will be administered by trained and knowledgeable personnel.

Assistive Technology Assessment conducted by a qualified professional includes a functional evaluation of the child in the child's customary environment to determine the need for assistive technology services or devices.

Audiological Evaluation is conducted by an audiologist or ear, nose, and throat specialist using a variety of tests and measurements, depending on the unique needs of the child, to determine auditory impairment and the range, nature and degree of hearing loss and communication functions and to identify appropriate audiological services.

Behavioral Assessment is a process for gathering information that appropriately addresses a child's behavioral needs and identifies appropriate behavioral supports. Behavioral assessments are conducted by qualified professionals who have experience and training in assessment and data interpretation.

Developmental Evaluation is the process by which qualified professionals together with families, through standardized norm-referenced tests and/or criterion-referenced tests, along with observations, look at all areas of a child's development: motor, communication, cognitive, social/emotional, and adaptive (self-help) skills to determine eligibility for early intervention services.

Developmental Assessment is the ongoing process of observing and identifying a child's current competencies (including knowledge, skills, and behavior/personality/social) and the best way to help the child increase these competencies.

Functional Vision Assessment is a process to determine what the child can see and how he/she responds to items encountered in his/her environment. The assessment is conducted by a professional (typically a vision specialist, special educator, occupational therapist, or optometrist) trained to observe how vision will affect the child's ability to function in daily routines and to describe optimal environmental conditions for encouraging adaptive use of vision.

Vision Evaluation is conducted by a professional eye-care specialist in order to obtain an initial diagnosis and appraisal of specific visual disorders, delays, and abilities to determine eligibility for early intervention services.

Nursing Assessment is an assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems.

Nutrition Assessment includes conducting assessments in nutritional history dietary intake; anthropometric, biochemical and clinical variables; feeding skills and feeding problems; and food habits and food preferences. These assessments will help in addressing the nutritional needs of children eligible for early intervention services. A nutritional assessment that includes a nutritional history, feeding habits and food preferences, dietary intake, and anthropometric, biochemical and clinical variables may be conducted by a registered dietician. Feeding skills and feeding problems may be

assessed by a speech therapist or an occupational therapist. Food habits and preferences may be obtained by dieticians, special educators, nurses, care coordinators, or other qualified professionals.

Observations are conducted by qualified professionals in a variety of settings, situations, interactions, and/or activities as part of the evaluation for eligibility and/or assessment to determine appropriate methods and strategies for early intervention services.

Occupational Therapy Evaluation is conducted by an occupational therapist to identify visual/motor, sensory integration, perceptual motor, or fine motor dysfunction.

Occupational Therapy Assessment is conducted by an occupational therapist to assess the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor and postural development and to determine the need for services designed to improve the child's functional ability to perform tasks in the home, school, and community.

Physical Therapy Evaluation is conducted by a physical therapist to identify movement dysfunction for the purpose of determining eligibility for early intervention services.

Physical Therapy Assessment is conducted by a physical therapist to address sensorimotor function through assessment of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and environmental adaptation needs and to identify methods, strategies, and services to meet the needs of the eligible child.

Psychological Evaluation is conducted by a psychologist or psychological examiner using standardized or criterion-referenced evaluations to determine cognitive ability skills and learning patterns of the child in order to establish the child's eligibility for early intervention services.

Psychological Assessment is conducted by a psychologist or psychological examiner to obtain, integrate, and interpret information about child behavior and child and family conditions related to learning and to mental health and development in order to determine the need for psychological services.

Speech/Language Evaluation is conducted by a speech/language therapist/pathologist in order to identify communicative disorders or oropharyngeal disorders and delays in communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills through standardized and criterion-referenced instruments to determine eligibility for early intervention services.

Speech/Language Assessment is conducted by a speech/language therapist/pathologist to determine methods, services, and strategies for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills.

Social/Emotional Developmental Assessment of the child is conducted by a qualified professional within the family context in order to identify resources and services to enable the child and family receive benefits from early intervention services.

Vision/Hearing Screening is conducted by trained professionals to rule out possible visual acuity difficulties and possible auditory deficiencies.

Medical service for diagnostic or evaluation purposes means service provided by a licensed physician to determine a child's developmental status and need for early intervention services.

Family Assessment is the ongoing process by which qualified professionals gather information in order to help the family determine priorities for goals and services in addition to identifying the family's concerns and resources as they relate to enhancing the development of their child.

Evaluation Tools
for Determining Eligibility for Early Intervention Services

Developmental Instruments

Battelle Developmental Inventory (BDI)
Bayley Scales of Infant Development, 2nd Edition (BSID-II)
Developmental Assessment of Young Children (DAYC)
Developmental Observation Checklist System (DOCS)
Infant-Toddler Developmental Assessment (IDA)
Mullen's Scales of Early Learning
Neonatal Behavior Assessment Scale (NBAS)
Syracuse Play-Based Assessment (SPBA)
Transdisciplinary Play-Based Assessment

Domain Specific Instruments*

Adaptive
Pediatric Evaluation of Disability Inventory

Communication
Communication and Symbolic Behavior Scales (CSBS)
MacArthur Communicative Development Inventory (CDI)
Preschool Language Scale-3 (PLS-3)
Sequenced Inventory of Communication Development, Revised (SICD-R)

Motor
Peabody Developmental Motor Scales (PDMS)
Test of Sensory Functions in Infants (TSFI)

Social-Emotional
Vineland Social-Emotional Early Childhood Scales (Vineland SEEC)
Temperament and Atypical Behavior Scale (TABS)

*These instruments require an additional developmental evaluation/assessment tool to complete eligibility determination.

Battelle Developmental Inventory (BDI)

- Authors: J. Newborg, J.R. Stock & J.Wnek (initial development); J.Guidubladi (pilot norming study); J.S. Sviniciki (completion and standardization)
- Year: 1988
- Assessment type: Norm based/curriculum compatible; used for diagnosis, evaluation; and program development
- Ages: Birth to age 8
- Domains: Personal-Social, Adaptive, Motor, Communication, and Cognitive
- Adaptations: General adaptations for various disabilities; standardized stimulus/response options for visual, hearing, neuromotor, and behavior/emotional disorders included in most items.
- Scores: Domain scores (developmental age, z-score, developmental rate, normal curve equivalent, percentile), standard scores; and age equivalents
- Standardization: Stratified random sampling, within the guidelines of the US census, was used to select the norming sample, which was administered to more than 800 children.
- Validation: BDI reports adequate reliability, and initial validity studies show significant correlation between the BDI and a variety of measures, such as Standford-Binet Form L-M. A weak correlation was observed between the BDI and the WISC-R Full Scale IQ. There has been a recent criticism about the use of the BDI as a norm-referenced measure for special services eligibility because of difficulty calculating extreme standard scores in a reliable fashion. The BDI received higher marks for use as a criterion referenced measure. (Wodrich, 1997)
- User Qualifications: It is primarily designed for use by infant, preschool, and primary teachers as well as by special educators. Speech pathologists, psychologists, adaptive physical education specialists, and clinical diagnosticians will also find the BDI effective in measuring the functional abilities in young disabled and nondisabled children. Although appropriate for non-psychologists supervised practice in administration for preschoolers with disabilities is critical. (Bagnato, 1997)
- Ordering information: Riverside Publishing
  425 Spring Lake Drive
  Itasca, IL 60143-2079
  800/323-9540 (orders)
  800/767-8420 (general business)

Bayley Scales of Infant Development, 2nd Edition (BSID-II)

- Author: Nancy Bayley
- Year: 1993
- Assessment Type: Standardized norm-referenced assessment of cognitive and motor development used to identify children who are developmental delayed, to chart a child's progress after initiation of an intervention program, as a tool for teaching parents about their infants development; and as a research tool.
- Ages: 1 to 42 months
- Domains: Mental Scale; Motor Scale; and Behavior Rating Scale
- Scores: Standard scores; scaled scores;
- Standardization: Renormed on stratified sample of 1700 children reflecting geographic and cultural diversity. Data are provided for the following groups: premature infants, HIV positive, prenatal drug exposure, birth asphyxia, frequent otitis media, developmental delay, autistic, Down syndrome.
- Validation: Correlation of .57 was obtained with the Stanford-Binet for a sample of 120 (ages 24 to 30 months) children in the standardization group.
- User Qualifications: A graduate degree in Psychology, Education or closely related field that includes advanced training in the administration and interpretation of psychological tests; OR membership in a professional association that requires training and experience in the ethical and competent use of psychological tests; OR licensed or certified by an agency which does the same.
- Ordering information: Psychological Assessment Resources, Inc.
  16204 N. Florida Ave.
  Lutz, FL 33549
  813/968-3003
  800/331-8378
  Fax: 800/727-9329
  www.parinc.com

Communication and Symbolic Behavior Scales (CSBS)

- Authors: Amy Miller Wetherby, Barry Prizant
- Year: 1993
- Assessment Type: Standardized method of examining communicative and symbolic behaviors for the purpose of early identification of communication delays or disorders. This instrument requires an additional developmental evaluation/assessment tool to complete eligibility determination.
- Ages: Developmental: 8-24 months
  Chronological: 9 months-6.0 years
- Domains: Communication functions; gestural communication means; vocal communication means; verbal communication means; reciprocity; social-affective signaling, and symbolic behavior
- Scores: Standard scores or percentile ranks may be obtained for both the clusters and a communication composite. Norms may be computed based on chronological age or language stage.
- Standardization: The norming sample consisted of approximately 280 children. The CBSC has been tested for cultural bias with African-American children.
- Validation: The internal consistency coefficients ranged from .17 for social-affective signaling to .91 for vocal communication means (all other clusters were .58 or greater). The internal consistency coefficient for the communication composite was .91. Interrater reliability ranged from .83 to .90. Validity was studied using discriminate analysis and correlational analysis, with intercorrelations among cluster raw scores being moderate to high. (Riverside, 1999)
- User Qualifications: Recommended that this test be given by a speech/language pathologist, early intervention professionals or other professionals trained to perform developmental
- Ordering information: Riverside Publishing
  425 Spring Lake Drive
  Itasca, IL 60143-2079
  800/323-9540 (orders)
  800/767-8420 (general business)
  www.riverpub.com

Developmental Assessment of Young Children (DAYC)

- Authors: Judith K.Voress and Taddy Maddox
- Year: 1998
- Assessment Type: Developmental assessment through observation, interview of caregivers, and direct assessment. May be used in an arena assessment.
- Ages: Birth through 5 years, 11 months
- Domains: Cognition, Communication, Social-Emotional, Physical and Adaptive
- Scores: Standard scores; percentile scores and age equivalent. The test gives a General Development Quotient if all 5 subtests are completed, but all subtest can be used independently for each domain.
- Standardization: Normed on national sample of 1,269 individuals, broken into 23 age groups. Characteristics of the normative sample approximate the 1996 census.
- Validation: Reliability coefficients range from .90 to .99. Reliabilities for children identified as environmentally at-risk and biologically at-risk are .98 and.99. (PRO-ED)
- User Qualifications: Basic understanding of test and testing statistics; knowledge of general procedures governing test administration, scoring, and interpretation; and specific information about developmental evaluations.
- Ordering Information: PRO-ED
  8700 Shoal Creek Blvd.
  Austin, TX 78757
  800/897-3202
  512/451-3246
  FAX: 512/451-8542
  www.proedinc.com

Developmental Observation Checklist System (DOCS)

- Authors: W. P. Hresko; S.A. Miguel, R. J. Sherbenou, & S.D. Burton
- Year: 1994
- Assessment Type: A three-part inventory/checklist system with respect to general development (DC), adjustment behavior (ABC) and parent stress and support (PSSC). Provides a parent-report questionnaire.
- Ages: Birth through age 6
- Domains: Language, Motor, Social, and Cognitive
- Scores: Quotients, NCE scores, age equivalents and percentiles
- Standardization: Normed on more than 1400 children birth through age 6 from more than 30 states. Characteristics of the normative group approximate those for the 1990 Census data relative to gender, geographic region, race/ethnicity, and urban/rural residence.
- Validation: Construct validity is supported through correlations with age and group differentiation relating test items to total test scores, component intercorrelations, and cognitive aptitude. Substantial content validity and criterion-related validity is offered. (PRO-ED)
- User Qualifications: Basic understanding of test and testing statistics; knowledge of general procedures governing test administration, scoring, and interpretation; and specific information about developmental evaluation.
- Ordering Information: PRO-ED
  8700 Shoal Creek Blvd.
  Austin, TX 78757
  800/897-3202
  512/451-3246
  FAX: 512/451-8542
  www.proedinc.com

Infant-Todder Developmental Assessment (IDA)

- Authors: S. Provence, J. Erikson, S. Vater, & S. Palmeri
- Year: 1995
- Assessment Type: A comprehensive, multidisciplinary, family-centered process designed to improve early identification of children who are developmentally at risk.
- Domains: Province Birth to Three Developmental Profile, IDA Parent Report, and IDA Health Recording Guide- which focus on motor, language, cognitive-adaptive, feelings, social adaptation, and personality trait domains, as well as various subdomains, and integrated developmental concerns, health concerns, and family strengths and priorities related to the IFSP.
- Ages: Birth to age three
- Scores: Percentage delay computations based on norm-based (age), but not norm groups statistics.
- Standardization: Field-validation sample: Empirical data for the Province Birth to Three Developmental Profile was gathered by analyzing results of 100 infants and toddlers, ages birth to 3 years in a IDA training center. Test results were gathered from the IDA assessment administered by IDA practitioners at 23 different service agencies.
- Validation: Reliability coefficients for the Province domain scores generally range from .90 to .96 for ages 1-18 months and ,78 to ,96 for ages 19-36 months. Interrater reliabilities range from .91 to .95 for seven of the eight domains.
- Format: Parent Report is available in Spanish.
- User Qualifications: The professionals should have core knowledge of the basic skills necessary to conduct the IDA. All practitioners who have completed basic academic and clinical programs can incorporate IDA into their practice. Practitioners can be from the following professions**:** child development specialists; child psychiatrists; early childhood special educators; early intervention professionals; nurses, and nurse practitioners; occupational therapists; physical therapists, physicians; physician assistants; psychologists; school psychologists; social workers; speech and language pathologists; audiologist
- Ordering information: Riverside Publishing
  425 Spring Lake Drive
  Itasca, IL 60143-2079
  800/323-9540 (orders)
  800/767-8420 (general business)

MacArthur Communicative Development Inventories (CDI)

- Authors: L. Fenson, P. S. Dale, J. S. Reznick, D. Thal, E. Bates, J. P. Hartung, S. Pethick, J. S. Reilly
- Assessment Type: Parent completed, standardized checklists
- Domains: Communication
- Ages: *CDI Words and Gestures* is for children ages 8 through 16 months. *CDI Words and Sentences* is for children 16 through 30 months.
- Scores: Percentile scores based on age and gender
- Format: Spanish adaptation available. It does not yield a standard score.
- User Qualifications: Master's-level degree in Psychology or Education or the equivalent in a related field with relevant training in assessment. Or: Verification of membership in, or certification by, a professional association recognized by The Psychological Corporation to require training and experience in a relevant area of assessment consistent with the expectations outlined in the 1985 *Standards for Educational and Psychological Testing*.
- Ordering Information: Communication Skill Builders
  The Psychological Corporation
  PO Box 839954
  San Antonio, TX 78283-3954
  800/211-8378
  FAX: 800-232-1223
  www.PsychCorp.com

Mullen's Scales of Early Learning

- Author: Eileen M. Mullen
- Year; 1995
- Assessment Type: A comprehensive developmental assessment that is intended for children of all ability levels. This tool is used in conjunction with the Vineland Social-Emotional Early Childhood Scales to provide a complete developmental evaluation.
- Domains Gross Motor; Visual Reception; Fine Motor; Expressive Language and Receptive Language.
- Ages: Birth to 5 years, 8 months
- Scores: T scores, percentile ranks; age equivalents
- Standardization: Sample included 1,231 children (0 to 38 months) stratified by age, gender, race, parental occupation, and urban/rural residence. Subjects were selected from over 100 sites representing all major geographic regions of the US.
- Validation: Reliability for internal consistency ranges from median-.75 in Fine Motor to median-.91 in Early Learning Composite. The test-retest ranges from .82 in receptive language to .96 in gross motor for the 1-25 month group; and .71 in expressive language to .79 in fine motor for the 25-56 month group. (AGS)
- User Qualifications: User has completed a recognized graduate training program in psychology with appropriate coursework and supervised practical experience in the administration and interpretation of clinical assessment instruments; OR administrators should have completed graduate training and have experience in clinical infant assessment.
- Ordering Information American Guidance Service
  4201 Woodland Road
  PO Box 99
  Circle Pines, MN 55014-1796
  800/328-2560
  FAX: 800/471-8457
  www.agsnet.com

Neonatal Behavioral Assessment Scale (NBAS), 3rd ed.,

- Authors: T. Berry Brazelton & J. Kevin Nugent.
- Year: 1996
- Assessment Type: This instrument assesses a broad range of neonatal behaviors. It's goal is to identify children who are at risk and determine which of the children require early intervention. It is appropriate for at risk, atypical, and normal infants.
- Ages: Newborns up to two months.
- Domains: 28 behavioral items and 18 reflex items. It assesses different subsystems. The items are grouped into six behavior clusters (habituation, autonomic, motor, state organization, state regulation, and social-interactive behavior) and one reflex cluster.
- Scores: Scores on the behavioral scale are rated on a 9-point scale; reflex is scored on a 3 point scale. Performance on each dimension can be described as optimal, normal, or inadequate.
- Standardization: Formulated in 1973, by anthropologist, pediatrician, and psychologists, the NBAS is the has been used extensively in research and practice. One concern has been the lack of norming. For the first edition only 54 healthy, problem-free infants from a single hospital were used in the norm sample. However, an effort is underway to establish a representative normative base comprising healthy, problem-free infants. (Wodrich, 1997).
- Validation: Validity questions have been approached by predictive criterion-related test. When compared with 18 month scores on the Bayley Scales of Infant Development for both term and pre-term infants, the recovery curve scores were related significantly to mental and motor performance on the Bayley Scales of Infant Development; from 42% to 63% variance on the 18 month scores was predicted by the NBAS. (O'Donnell, 1996)
- User Qualifications: Examiners should have an adequate background in infant development in order to interpret the infant's behavior. Certification as an NBAS examiner involves both self-training and reliability training.
- Ordering Information: Riverside Publishing
  425 Spring Lake Drive
  Itasca, IL 60143-2079
  800/323-9540 (orders)
  800/767-8420 (general business)
  www.riverpub.com

Peabody Developmental Motor Scales (PDMS)

- Authors; M. Rhonda Folio, Rebecca Fewell
- Year: 1983
- Assessment Type: A motor development program that provides both an in-depth norm-referenced standardized assessment and instructional programming. This instrument requires an additional developmental evaluation/assessment tool to complete eligibility determination.
- Ages: Birth to 6 years, 11 months
- Domains: Fine motor: grasping, hand use, eye-hand coordination, and finger dexterity; and Gross motor: reflexes, balance, nonlocomotor, locomotor, receipt and propulsion.
- Scores: Scaled scores (z-scores, T-scores, developmental motor quotients), age scores, basal and ceiling age levels
- Standardization: Sample of 617 children stratified by age, race, gender, and regional distribution.
- Validation: Concurrent validity between the PDMS Fine Motor total and the Bayley Mental and Psycho-Motor Scales are .78 and .36 respectively. (Selected Tools)
- User Qualifications: May be administered by a wide variety of persons experienced with children once procedures have been learned; agreement reliability with an experienced examiner (85%) is recommended.
- Ordering Information**:** Riverside Publishing
  425 Spring Lake Drive
  Itasca, IL 60143-2079
  800/323-9540 (orders)
  800/767-8420 (general business)
  www.riverpub.com

Pediatric Evaluation of Disability Inventory (PEDI)

- Author: Stephen M. Haley, Wendy J. Coster, Larry H. Ludlow, Janet T. Haltiwanger, and Peter J. Andrellos
- Year: 1992
- Assessment Type: A criterion-based assessment that provides a descriptive measure of function in children with a variety of disabilities, especially those with physical and cognitive disabilities. This instrument requires an additional developmental evaluation/assessment tool to complete eligibility determination.
- Ages: 6 months to 7.5 years
- Domains: Three content domains: (1) self-care, (2) mobility, and (3) social function
- Scores: Standard and scaled performance scores
- Standardization: 412 children and families in MA, CT, and NY, stratified by age, gender, race and origin, level of parent education, community size and family marital and socioeconomic status.
- Validation:
- User Qualifications: Should be administered by a professional with background in pediatrics, experience with young children with disabilities and an understanding of tests and measures.
- Ordering Information: The Psychological Corporation
  PO Box 839954
  San Antonio, TX 78283-3954
  800/211-8378
  FAX: 800-232-1223
  www.PsychCorp.com

Preschool Language Scale-3 (PLS-3).

- Author: Irla Lee Zimmerman, Violette G. Steiner, Roberta Evatt Pond
- Year: 1992
- Assessment Type: A standardized assessment. This instrument requires an additional developmental evaluation/assessment tool to complete eligibility determination.
- Age: Birth to 6 years
- Accommodation: Suggested modifications for children with physical or hearing impairments
- Domain: Two subscales: Auditory Comprehension and Expressive Communication to assess language precursors, semantics, language structure and integrative thinking skills
- Standardization: Sample on 1200 children ages 2 weeks through 6 years, 11 months. Within each age group, 50 percent were female and 50 percent were male. A representative same based on the 1980 US Census, 1986 update, was stratified on the basis of parent education level, geographic region, and race.
- Validation:
- Format: Spanish-language version available
- User Qualifications: Verification of a Master's degree in Psychology or Education or the equivalent in a related field with relevant training in assessment; OR Verification of membership in or certification by. a professional association recognized by The Psychological Corporation to require training and experience in a relevant area of assessment consistent with the expectations outlined in the 1985 *Standards for Educational and Psychological Testing.*
- Ordering Information: The Psychological Corporation
  PO Box 839954
  San Antonio, TX 78283-3954
  800/211-8378
  FAX: 800-232-1223
  www.PsychCorp.com

Sequenced Inventory of Communication Development, Revised (SICD-R)

- Authors: Dona Lea Hedrick, Ph. D, Elizabeth M. Prather, Ph. D., and Annette R. Tobin, M. S. P. A.
- Year: 1984
- Assessment Type: A norm-referenced diagnostic test that evaluates and quantifies communication skills of normal and developmentally delayed children. This instrument requires an additional developmental evaluation/assessment tool to complete eligibility determination.
- Ages: 4 to 48 months
- Domains: Receptive: sound and speech discrimination, awareness, and understanding; and Expressive: behavior (imitating, initiating, and responding) expressive measurement (length and grammatical and syntactic structures of verbal output and articulation).
- Scores: Receptive communication age; and expressive communication age. Assignment of age levels is limited to estimation of child's level of development. (Kurtz, 1996).
- Standardization: 252 children, 21 at each of 12 age levels ranging from 4 to .48 months. Subjects were representative of the general population of Seattle, WA. Children whose parents judged their language to be abnormal, who were living in bilingual home, who displayed obvious physical or mental abnormalities, who had abnormal hearing, or who had ear pathologies within six weeks prior to testing were excluded from the sample.
- Validation: Reliability for test-retest is .90; Inter-rater is .90. Reviewers emphasize construct validity only. (Selected Instruments)
- Format: Cuban-Spanish edition
- User Qualifications: Speech/language pathologists, teachers in preschool programs, special education teachers, and psychologist.
- Ordering information; Western Psychological Services
  12031 Wilshire Blvd
  Los Angeles, CA 90025-1251
  800/648-8857
  FAX: 310/478-7838
  www.wpspublish.com

Syracuse Play-Based Assessment (SPBA) *Available late 2000*

- Authors: G. Ensher, E. Gardner, T. Bobish, C. Michaels, K. Butler,C. Reinson, D. Foertsch, and C. Cooper
- Year: 1999
- Assessment Type: A play-based assessment of early development. The SDA and its companion norm-referenced assessment, the Syracuse Play-Based Assessment (SPBA), were developed by a transdisciplinary team. The SPBA uses 1) parent report; 2) direct observation of parent-child interactions during play; 3) direct observation of the child in free play with and examiner (unfamiliar adult); and 4) interactions with the child in structured play with an examiner. It is designed for eligibility determination based on norms
- Ages: Birth to 36 months
- Domains: Neuromotor, sensation and perception, cognition, language and communication, social-emotional behavior, and adaptive behavior.
- Scores: Standard scores and percentile ranks
- Accommodations: Administration is flexible and encourages accommodating individual differences. Provides scaffolding in suggested levels of assistance for children who do not exhibit fully developed forms of skills.
- Standardization: Research and trial spanning 10 years support the item content, standardization procedures, reliabilities, and approximate norms; norming and validation are ongoing across the US ((1997). .

Validation: Not completed at this time.

- User Qualifications: Professional skills, knowledge of development and content of assessment manual. Training tape and workshop available.
- Ordering Information: Applied Symbolix, Inc.
  800 N. Wells Street
  Chicago, IL 60610
  800/676-7551
  313/787-3772
  www.symbolix.com

Temperament and Atypical Behavior Scale (TABS)

- Authors: Stephen J. Bagnato, John T. Neisworth, John Salvia & Frances M. Hunt
- Year: 1999
- Assessment Type: Norm-referenced screening and assessment tool designed to identify temperament and self-regulation problems that may indicate a child's risk for developmental delay.
- Domains: Atypical behavior in four categories-detached, hypersensitive/active, underreactive, and dysregulated.
- Ages: 11-71 months
- Scores: Normative means, standard deviations, and cut-off scores for both typical and atypical samples
- Standardization: Normed on 1000 young children from diverse socioeconomic and ethnic backgrounds developing typically and atypically.
- Validation: Research validated the Regulatory Disorder Axis of the *Diagnostic Classification System: 0-3,* published by ZERO TO THREE: National Center for Infants, Toddlers, and Families.
- User Qualifications: Early childhood professionals
- Ordering information: Paul H. Brookes
  PO Box 10624
  Baltimore, MD 21285-0624
  1-800-638-3775
  Fax: 1-410-337-8539
  www.brookespublishing.com

Test of Sensory Functions in Infants (TSFI)

- Authors: Georgia A. DeGangi, Ph.D, OTR and Stanley I. Greenspan. M/ D.
- Year: 1989
- Assessment Type: A criterion-referenced tool designed to provide an overall measure of sensory processing and reactivity in infants with regulatory disorders, developmental delays, and those at risk for learning disorders; to be used in conjunction with other developmental test to provide an overall indicator of the child's developmental functioning.
- Ages: 4 to 18 months
- Domains: Five domains of sensory processing and reactivity: reactivity to tactile deep pressure, adaptive motor functions, visual-motor integration, ocular-motor control, and reactivity to vestibular stimulation.
- Scores: Criterion-referenced
- Standardization: Not standardized
- Validation: Criterion validated for interobserver reliability, decision consistency reliability, and test-retest reliability using samples of normal, regulatory-disordered, and developmentally delayed infants
- User Qualifications: Not specified
- Ordering Information: Western Psychological Services
  12031 Wilshire Blvd
  Los Angeles, CA 90025-1251
  800/648-8857
  FAX: 310/478-7838
  www.wpspublish.com

Transdisciplinary Play-Based Assessment (TPBA)

- Authors: Toni Linder and invited contributors
- Year: 1993
- Assessment Type: Curriculum embedded, diagnostic comprehensive model for assessing a child's developmental level, learning styles, temperament, motivation, and interactional patterns. It is not a standardized, norm-based assessment, nor is it a checklist of developmental skills.
- Ages: Infancy to 6 years of age.
- Domains: Cognitive, social-emotional communication and language, and, sensorimotor domains
- Scores: By using observation and age charts for each developmental area along with observation and summary worksheets, team members are able to identify child strengths, area of concern and area of readiness procedures for TPBA consists of six phases of flexibly administered unstructured and structured activities in which the child plays alone, with a parent/caregiver, and with a peer. A team makes observations while the child plays.
- Adaptations: The curriculum is flexible and accommodates several special needs.
- Standardization: Not standardized
- Validation: Few supporting data provided for program efficacy; however, TBPA is widely used and is endorsed in a number of states. (Bagnato, 1997)
- User Qualifications: Can be used by professionals with expertise in the content areas in conjunction with parents.
- Ordering Information: Brookes Publishing Co.
  PO Box 10624
  Baltimore, MD 21285-0624
  800/638-3775
  FAX: 410/337-8539
  www.pbrookes.com

Vineland Social-Emotional Early Childhood Scales (Vineland SEEC)

- Authors: Sara S. Sparrow, David A. Balla, & Domenic V. Cicchetti
- Year: 1998
- Assessment Type: The SEEC Scales identify strengths and weaknesses in specific areas of social-emotional behavior, the test results can be used to plan a program and select activities best suited to the child's needs. The data is collected through an interview with the parent or caregiver. This tool is used in conjunction with the Mullen's Scale of Early Learning to provide a complete developmental evaluation.
- Ages: Birth through 5 years, 11 months
- Domains: It consists of three scales-Interpersonal Relationships, Play and Leisure Time, and Coping Skills- and the Social-Emotional Composite.
- Scores: Standard scores, percentile ranks, stanines, and age equivalents
- Standardization: Norms were developed using data gathered from the early childhood sample (birth to 5 years, 11 months) from the Vineland ABS national tryout and standardization. The final sample was chosen from subjects that best matched the 1980 US Census data. The subjects were regrouped into 6 age groups or 200 subjects each.
- Validation: The results of the studies of convergent and discriminate validity, test-criterion relationships, factor analysis, and developmental progression support the construct validity as a measure or personal and social sufficiency. (Sparrow, 1998).
- Formats: Manual includes Blackline Masters of Report to Parents (in English and Spanish)
- User Qualifications User has completed a recognized graduate training program in psychology with appropriate coursework and supervised practical experience in the administration and interpretation of clinical assessment instruments.
- Ordering Information American Guidance Service
  4201 Woodland Road
  PO Box 99
  Circle Pines, MN 55014-1796
  800/328-2560
  FAX: 800/471-8457
  www.agsnet.com

Bibliography

Bagnato, S.J., Neisworth, J. T., & Munson, S. M. (1997). *Linking assessment and early intervention: An authentic curriculum-based approach.* Baltimore, MD: Paul H. Brookes.

Kurtz, L. .A., Dowrick, P.W., Levy, S. E. & Batshaw, M. L. (1996). *Handbook of developmental disabilities.* Gaithersburg,MD: Aspen Publishers.

O'Donnell, K. (1986). The family system in neonatal care. In D. Slaton (Ed.), *Special care for special babies.* Chapel Hill, NC: University of North Carolina. In M. McClean, D. Bailey & M. Wolery, *Assessing infants and preschoolers with special needs,* Englewood Cliffs, NJ: Prentice Hall.

Sparrow, S. S., Balla, D. A.& Cicchetti, D. V. (1998). *Vineland social-emotional early childhood scales manual.* Circle Pines, MN: American Guidance Service, Inc.

Wodrich, D. L. (1997). *Children's psychological testing: A guide for nonpsychologists.* Baltimore, MD: Paul H. Brookes.

national early childhood TA Center

IDEAs ★ partnerships ★ results

NECTAC Notes
Issue No. 10
May 2002

Informed Clinical Opinion

by Jo Shackelford

Based on previous paper by
Patti Biro, Deb Daulton, and Eleanor Szanton,
in consultation with Constance Garner

The term "informed clinical opinion" appears in the regulatory requirements for the implementation of Part C of the Individual with Disabilities Education Act (IDEA) as an integral part of an eligibility determination (see Table 1). It must be included in evaluation and assessment procedures, since it is a necessary safeguard against eligibility determination based upon isolated information or test scores alone. Since the term carries different meanings for individuals and agencies, it is important to clarify the meaning and use of "informed clinical opinion" in the context of Part C. This document uses a question-and-answer format to address three key issues:

- ★ What does informed clinical opinion mean in the context of Part C?
- ★ How does informed clinical opinion affect the determination of eligibility?
- ★ Why is it necessary to document informed clinical opinion?

What does informed clinical opinion mean in the context of Part C?

Informed clinical opinion is used by early intervention professionals in the evaluation and assessment process in order to make a recommendation as to initial and continuing eligibility for services under Part C and as a basis for planning services to meet child and family needs. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. For example, a physical therapist must make judgments about muscle tone abnormality based on the therapist's training and experience with other children. Likewise, a psychologist may note in observing a child playing that she performs tasks in adaptive ways not permitted during the administration of a standardized cognitive assessment.

Continued...

Table 1

Part C Regulations Pertaining to Informed Clinical Opinion

Subpart D - Program and Service Components of a Statewide System of Early Intervention Services.

§ 303.300 State eligibility criteria and procedures.

General
Each statewide system of early intervention services must include the eligibility criteria and procedures, consistent with § 303.16, that will be used by the State in carrying out programs under this part.
(a) The State shall define developmental delay by—
(1) Describing, for each of the areas listed in Sec. 303.16(a)(1), the procedures, including the use of informed clinical opinion, that will be used to measure a child's development; and
(2) Stating the levels of functioning or other criteria that constitute a developmental delay in each of those areas.
(b) The State shall describe the criteria and procedures, including the use of informed clinical opinion, that will be used to determine the existence of a condition that has a high probability of resulting in developmental delay under § 303.16(a)(2).

NOTE: Under this section and § 303.322(c)(2), States are required to ensure that informed clinical opinion is used in determining a child's eligibility under this part. Informed clinical opinion is especially important if there are no standardized measures, or if the standardized procedures are not appropriate for a given age or development area. If a given standardized procedure is considered to be appropriate, a State's criteria could include percentiles or percentages of levels of functioning and standardized measures.

§ 303.322 Evaluation and assessment.

(c) *Evaluation and assessment of the child.* The evaluation and assessment of each child must –

(1) Be conducted by personnel trained to utilize appropriate methods and procedures;
(2) Be based on informed clinical opinion; and
(3) Include the following:
(i) A review of the pertinent records related to the child's current health status and medical history.
(ii) An evaluation of the child's level of functioning in each of the following developmental areas:
(A) Cognitive development;
(B) Physical development, including vision and hearing;
(C) Communication development;
(D) Social or emotional development; and,
(E) Adaptive development.

§ 303.323 Nondiscriminatory procedures.

Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that –

(a) Tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so;

(b) Any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory;

(c) No single procedure is used as the sole criterion for determining a child's eligibility under this part; and

(d) Evaluations and assessments are conducted by qualified personnel.

Early Intervention Program for Infants and Toddlers With Disabilities Rule (2001).

The knowledge and skill of the early intervention multidisciplinary team, including the parents, constitute the basic foundation for the process of becoming "informed" about a child's developmental status within a socially valid context. In essence, they seek to answer the question, What are the child's abilities and needs within his/her natural environment? Thus, appropriate training, previous experience with evaluation and assessment, sensitivity to cultural needs, and the ability to elicit and include family perceptions are all important elements of informed clinical opinion.

The individuals and agencies responsible for implementing Part C need to consider **who** might have an informed clinical opinion, **what** these people might have an informed clinical opinion about, and **how** their informed clinical opinion can be integrated into the process of evaluation and assessment. In the context of Part C, these questions should be considered both at the level of the individual early intervention professional and at the level of the multidisciplinary team.

How does informed clinical opinion affect the determination of eligibility?

Informed clinical opinion should be taken into account at both the individual and team levels.

INDIVIDUAL TEAM MEMBER LEVEL The individual early intervention professional uses both qualitative and quantitative information to shape an informed clinical opinion about a child's development and need for early intervention services. To do so, the professional must have knowledge of the multiple domains of development characteristic of infants and toddlers; the expected sequence of development; and the broad range of individual variations that may be seen in appropriately developing infants and toddlers. In order to reach an informed clinical opinion about the development of a particular infant or toddler, the professional may use any or all of the following:

- ★ clinical interviews with parents;
- ★ evaluation of the child at play;
- ★ observation of parent-child interaction;
- ★ information from teachers or child care providers; and
- ★ neurodevelopmental or other physical examinations.

Information derived from these examples and additional psychometric and diagnostic data are synthesized to become the "informed clinical opinion" of an individual. The informed clinical opinion should reflect a meaningful assessment of the individual child's development and family resources, priorities, and concerns, and suggest areas that may require further evaluation.

TEAM LEVEL The multidisciplinary team, which includes family members, then synthesizes and interprets all available information, both qualitative and quantitative, about a child and family offered by the team participants.

This opportunity to integrate observations, impressions, and evaluation findings of the individuals facilitates a "whole child" approach to evaluation and assessment that goes beyond a reporting of test scores. In this way, the functional impact and the implications of noted delays or differences in development can be discussed and considered by the team in determining eligibility and developing the Individualized Family Service Plan (IFSP). Knowledge about available services is useful in formulating the IFSP, but should not limit the recommendations made by the team.

Why is it necessary to document informed clinical opinion?

Appropriate documentation of the sources and use of informed clinical opinion is important for two reasons. First, documentation provides a baseline against which to measure the progress and changing needs of the child and family over time. The initial recommendations of the multidisciplinary team reflect the needs of the child and family at a specific point in time. In Part C, assessment and subsequent eligibility determination is an ongoing process that may require modifications in the IFSP. The perceptions and impressions of individual early intervention professionals may change over time. Documentation of the individual and team findings can facilitate transition when families move, change service providers, or enter additional or new service delivery systems.

Secondly, documentation of the sources and use of informed clinical opinion also can provide information to assure that procedural safeguards were provided in the evaluation and assessment process and the determination of eligibility. This documentation should be maintained by a designated person, such as the interim or permanently assigned service coordinator and the parent.

Thus, the regulations regarding informed clinical opinion

are intended to accomplish the following: 1) ensure a dynamic assessment approach; 2) support and encourage the acquisition and interpretation of multiple sources of information as part of the evaluation and assessment process; and 3) permit greater compatibility between a child and family's needs and the provision of services.

References

Early Intervention Program for Infants and Toddlers With Disabilities Rule of 2001, 34 C.F.R. §303 (2001).

Citation

Please cite as:

Shackelford, J. (2002). *Informed clinical opinion* (NECTAC Notes No. 10). Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.

This document appears at http://www.nectac.org/pubs/pdfs/nnotes10.pdf and updates to the data herein will be announced at http://www.nectac.org/pubs/.

NECTAC Notes No. 10 is an update of NECTAS Notes #4 disseminated in 1991.

About the Authors

Jo Shackelford is a Technical Assistance Specialist for Part C with NECTAC. Her research interests include eligibility, interagency coordination, and health issues.

Patti Biro, Deb Daulton and Eleanor Szanton were formerly associated with NECTAS.

Constance Garner was a policy and program specialist for the U.S. Department of Education, Office of Special Education Programs, Early Childhood Branch, when the previous edition of this paper was prepared.

NECTAC Notes is produced and distributed by the National Early Childhood Technical Assistance Center (NECTAC), pursuant to contract ED-01-CO-0112 and no-cost extension of cooperative agreement number H024A-60001–96 with the Office of Special Education Programs, U.S. Department of Education (ED).

Additional copies of this document are available from NECTAC at cost. A list of currently available NECTAC publications can be viewed at our site on the World Wide Web or requested from us. NECTAC is committed to making the information it disseminates fully accessible to all individuals. To acquire this publication in an alternate format, please contact the Publications Coordinator in Chapel Hill.

NECTAC is a program of the FPG Child Development Institute at The University of North Carolina at Chapel Hill. The address is:

Campus Box 8040, UNC-CH
Chapel Hill, NC 27599-8040

919-962-2001 ★ phone
919-843-3269 ★ TDD
919-966-7463 ★ fax

nectac@unc.edu ★ www.nectac.org

Principal Investigator: Pascal Trohanis

Contracting Officer's Representative at OSEP: Peggy Cvach

Contract Specialist at U.S. ED: Dorothy Hunter

Publications Coordinator: Caroline Armijo

IDEAs that Work
U.S. Office of Special Education Programs

Informed Clinical Opinion Summary

Date of summary:_____
Child's name: _____ Date of birth:_____
Parent(s): _____
Address: _____
TEIS service coordinator: _____

Date(s) of family consultation: _____
Summary of family consultation: _____
_____

Additional documentation: _____
Referral source: _____
_____
Physician(s) and medical personnel: _____
_____
Child care provider: _____

Written documentation by qualified evaluators (attach reports if available or summarize results):

- Evaluation results and scores, if available: _____
  _____
- Qualitative observations: _____
  _____
  _____
- Statement of rationale for Informed Clinical Opinion request: _____
  _____
  _____
- Explanation of how early intervention will benefit child and family: _____
  _____
  _____

Informed Clinical Opinion team members (print names):

- Family: _____
- Evaluator: _____
- TEIS service coordinator: _____

Eligibility established by consensus of team members: Yes _____ No _____

Date of IFSP: _____
Due date of IFSP six-month review: _____

Children who are determined to be eligible based on informed clinical opinion must have eligibility and need for evaluations addressed at six-month IFSP review. The TEIS service coordinator must be involved at the six-month IFSP review.

Status of eligibility at six-month review: _____
Date of six-month review: _____
Summary of decision made at six-month review: _____

Informed Clinical Opinion Summary

Instructions

Required or Equivalent Form

Purpose: To provide documentation of eligibility by informed clinical opinion when the use of standardized instruments or measures will not accurately reflect the child's developmental status and when the child does not have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. CFR 303.300 (1) (2) (b)

Method: After the request for informed clinical opinion eligibility is received or initiated by TEIS, the TEIS service coordinator should implement the procedures to complete this form, following the guidelines established for determining eligibility based on informed clinical opinion.

Instructions:

1. Summarize the consultation with family regarding evaluation results, eligibility requirements, clinical observations, and any concerns.
2. Summarize the information collected from referral sources, physicians, medical personnel, and child care.
3. Gather and summarize written documentation from qualified evaluators or attach reports to this form, and/or
4. Summarize the qualitative observations made by a qualified evaluator.
5. Complete the statement regarding the rationale for informed clinical opinion request.
6. Complete the explanation of how early intervention will benefit the child and family.
7. List the team members which must include at least the family, evaluator, and TEIS service coordinator.
8. Check yes or no indicating whether a consensus was reached by the team members.
9. Enter the date of the IFSP and the due date of the IFSP six-month review.
10. After the six-month review, enter the status of the child's eligibility and the date the six-month review was completed.
11. Provide summary of decision made by the team members at the IFSP six-month review.

Summary of Communication Eligibility Guidelines

This handout summarizes pertinent contents from the TEIS booklet *Guidelines for Communication Eligibility Determination*. It is intended as a quick reference tool. It is important for the service coordinator to read the booklet in full. This tool may be useful as a quick reminder of key points.

If domain-specific evaluation (ex. PLS) in the area of communication by appropriately qualified personnel reveals:

- **25%** delay in **combined** expressive and receptive communication domain **and 25%** delay in **another area** of development

or

- **40%** delay in the **combined** expressive and receptive communication domain,

then the child is eligible.

- If the delay is **exclusively** in the area of **expressive** communication and is at **least 40%** below CA

or

- Delay is at least **25%** below CA in **expressive** communication **and** at least **25%** in **another developmental area**

the child may be eligible if at **least one** of the following factors is present:

1. Delayed oral motor development;
2. Moderate to severe speech impairment, (e.g. fewer than 65% of consonants correct in a five-minute continuous speech sample). This factor includes severe phonological impairment, phonological process impairment, suspected developmental apraxia of speech, and motor speech impairment;
3. Family history of speech-language impairment, hearing impairment, or developmental delay; or
4. Significant birth history including:
   - Congenital infection (e.g. toxoplasmosis, syphilis, rubella, cytomegalovirus)

- Craniofacial anomalies
- Birth weight less than 1500 grams (about 3 lbs.)
- Hyperbilirubinemia at a level requiring exchange transfusion
- Otoxic medications
- Bacterial meningitis
- Apgar scores of 0-4 at one minute and 0-6 at five minutes
- Mechanical ventilation lasting more than five days
- Head trauma associated with loss of consciousness or skull fracture (American Academy of Audiology, Joint Committee on Infant Hearing, 1994)

These factors must be **documented** either through medical records, additional assessment, or through behavioral observations. The evaluation report must identify why the child was determined to be eligible.

For children in a home where **English is not the primary language,** the evaluator must be able to demonstrate that the child has a **significant delay** in communication in his/her **primary or dominant language**, based on the above guidelines. An interpreter in the child's primary language shall be used in the evaluation. For those children who **do not have an appropriate interpreter** in the child's primary language, the procedures for establishing eligibility based on **Informed Clinical Opinion** shall be used.